

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Cecil

17462

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Bear Woodlawn

(No.)

154

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louisa B Baddus

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Scott(Address) Post-Deposit Ind15  
Filed Oct. 8th 1915 - J. R. Damon

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 8, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191 , to , 191 ,

that I last saw him alive on Oct 1st , 1915

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH \* was as follows:

Contributory Influenza & weakness  
(Duration) yrs. mos. de.(Signed) Dr. M. Peacock (Address) 646 (Duration) yrs. mos. de.(M. D.) Prague

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT

CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. de. In the State, yrs. mos. de.

Where disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Asbury Cemetery Oct 8, 1915

DATE OF BURIAL

20 UNDERTAKER

W.C. Jackson Baltimore

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis*,

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	NOV 5 1915
BUREAU, U. S.	



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

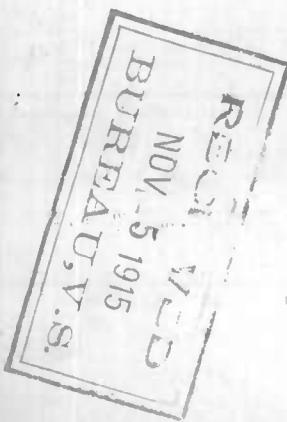
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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Mæasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL sepiphemma," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS or INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *lethamis*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Cecil

17464

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94Village or City Wilmington

(No. ....)

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still Born Infant - Abel & Mabel Cummins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u>
---------------------	------------------------------	--

6 DATE OF BIRTH

Oct 19, 1915  
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Cecil Md

## PARENTS

## 10 NAME OF FATHER

Abel Cummins11 BIRTHPLACE OF FATHER  
(State or country)Cecil Md

## 12 MAIDEN NAME OF MOTHER

Mabel Taylor13 BIRTHPLACE OF MOTHER  
(State or country)Cecil Co Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Abel G. Cummins  
(Address) North East Md.

15

Filed Oct 20, 1915 5 D. A. Biddle  
Locality

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 19, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191..., to ..... , 191...,

that I last saw h..... alive on ..... , 191...,

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH \* was as follows:

Still Born Infant

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) A. G. Cummins (Address) Wilmington WilmingtonOct 20, 1915 Wilmington

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) Means of INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Bayview DATE OF BURIAL Oct 20, 1915

## 20 UNDERTAKER

J. M. Pierson ADDRESS North East Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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1 PLACE OF DEATH County _____ Village or City _____		17 165 186
2 FULL NAME <i>John Caporoso</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>November 26, 1889.</i> (Month) (Day) (Year)		
7 AGE <i>76 yrs. 11 mos. 16 ds.</i>		
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Day Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Appliance &amp; Stone Co.</i>		
9 BIRTHPLACE (State or country) <i>Italy</i>		
PARENTS		
10 NAME OF FATHER <i>Rocco Caporoso</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Italy</i>		
12 MAIDEN NAME OF MOTHER <i>Adriana Cerasone</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Italy</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Rocco A. Caporoso</i>		
(Address) <i>216 Walnut St. Camden N.J.</i>		
15 Filed <i>10/23/15</i>	16 191	<i>L. G. Taylor</i>

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *97*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *October 10, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
191 to 191, and that I last saw him alive on 191,

and that death occurred on the date stated above, at 191 m.

## The CAUSE OF DEATH \* was as follows:

*Killed accidentally by premature explosion of dynamite. Cause of explosion  
Unknown.*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *W. P. Dean Coroner*  
*October 10, 1915* (Address) *Elton, Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where disease contracted,  
if not at place of death?

Former or  
usual residence

In the  
State, yrs. mos. ds.

## 19 PLACE OF BURIAL OR REMOVAL

*Camden N.J. Oct. 23, 1915*

## 20 UNDERTAKER

ADDRESS

*W. C. Jackson Blythdale*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

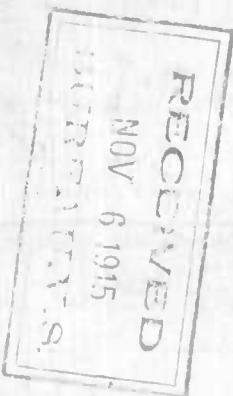
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1 PLACE OF DEATH County <u>Cecil</u>		15-89 120	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Eck Mills</u> (No.)		Registration Dist. No. <u>92</u>		
2 FULL NAME <u>Eva Sidney Carr</u>		St. _____ Ward _____		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	16 DATE OF DEATH <u>October 19</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Nov 29</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 6</u> 1915 to <u>Oct 19</u> 1915, that I last saw her alive on <u>Oct 19</u> 1915, and that death occurred on the date stated above, at <u>9 P.M.</u> The CAUSE OF DEATH* was as follows:		
7 AGE <u>25 yrs 11 mos 22 ds.</u>	If LESS than 1 day, _____ hrs. OR min. ?		<u>Acute Intestinal Obstruction</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u>				
8 OCCUPATION (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
10 NAME OF FATHER <u>Samuel Remond</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
12 MAIDEN NAME OF MOTHER <u>Susan Remond</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Eva Carr</u> (Address) <u>Eck Mills</u>				
15 Filed <u>Oct 22, 1915</u>	16 PLACE OF BURIAL OR REMOVAL <u>Crown Street</u> 17 DATE OF BURIAL <u>Oct 22, 1915</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>October 19</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 6</u> 1915 to <u>Oct 19</u> 1915, that I last saw her alive on <u>Oct 19</u> 1915, and that death occurred on the date stated above, at <u>9 P.M.</u> The CAUSE OF DEATH* was as follows:				
<u>Acute Intestinal Obstruction</u>				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>3 yrs 11 mos 22 ds.</u> In the State <u>25 yrs 11 mos 22 ds.</u> Where was disease contracted, If not at place of death? <u>Eck Mills Md</u>				
Former or usual residence <u>Eck Mills Md</u>				
19 PLACE OF BURIAL OR REMOVAL <u>Crown Street</u> 20 DATE OF BURIAL <u>Oct 22, 1915</u>				
21 UNDERTAKER <u>A. Albermarle</u> ADDRESS <u>Eck Mills Md</u>				

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

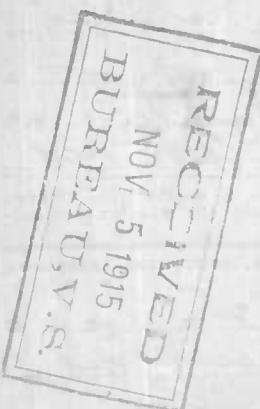
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lung*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <i>Leicester</i>		17467
Village or City <i>Near London</i>		(No. <i>156</i> )
2 FULL NAME <i>Frank Cavacece</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Married</i>
6 DATE OF BIRTH <i>Sept- 21</i>		(Month) (Day) (Year) <i>1888</i>
7 AGE <i>77 yrs. 10 mos. 19 ds.</i>		11 LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Steel Mill &amp; Blasting</i>		
8 OCCUPATION (b) General nature of industry business, or establishment in which employed (or employer) <i>United States Steel Co</i>		
9 BIRTHPLACE (State or country) <i>Italy</i>		
10 NAME OF FATHER <i>Julio Cavacece</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Italy</i>		
12 MAIDEN NAME OF MOTHER <i>Unknown</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Italy</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Interrogant) <i>Long O'Warrick</i>		
(Address) <i>Aberdeen Md</i>		
15 Filed <i>10/23/15</i>	191	L. G. Taylor

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *97*

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 10*, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
191 to 191, 191, to 191,

that I last saw him alive on 191, 191, to 191,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

*His death occurred by premature  
explosion of Artillery. Cause  
of explosion being unknown*

(Duration) yrs. mos. ds.

Contributory  
Secondary(Signed) *Wm P. Deacon, Coroner, Elton, Md*  
(Address) *181* (Duration) yrs. mos. ds.\* State the DISEASE, CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
at death yrs. mcs. ds. In the  
Where was disease contracted,  
if not at place of death?Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
*Mount Eden Cemetery Oct 23 1915*

20 UNDERTAKER

ADDRESS *W. C. Jackson, Blythdale*

REGISTRAR

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal*, *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-spinal meningitis* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsas*, *lethas*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	NOV 6 1915
U. S. C. S. T. I. S.	

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

17468

150

Village or City Colona Md. No. ....

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Earie clifton Crewee

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE,  
MARRIED,  
WIDOWED,  
DIVORCED  
(Write the word)

6 DATE OF BIRTH Oct 10 1915  
(Month) (Day) (Year)

7 AGE 1 yrs 11 mos 11 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work. none  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) none

9 BIRTHPLACE  
(State or country) near Colona Md.

10 NAME OF  
FATHER John F. Crewee

11 BIRTHPLACE  
OF FATHER  
(State or country) Port Deposit Md

12 MAIDEN NAME  
OF MOTHER Florance Pierce

13 BIRTHPLACE  
OF MOTHER  
(State or country) near Colona Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. F. Crewee (Father)

(Address) Colona Md.

15 Oct. 27, 1915 W. H. Cameron

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1915, to Oct 26, 1915,

that I last saw him alive on Oct 26, 1915,

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Malformation of heart  
Vascular disease

(Duration) yrs. mos. ds.  
Contributory Exhaustion  
Secondary

(Duration) yrs. mos. ds.  
(Signed) Ernest R. Land, M. D.  
Oct 27, 1915 (Address) Liberty Ward

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Mount Pleasant DATE OF BURIAL Oct 28th, 1915

20 UNDERTAKER S. B. Fink ADDRESS Colona Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

## Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma

etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 5 1915



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil

17469

164

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 97

Village or City Perryville (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

John E. Cresswell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

August 29, 1915  
(Month) (Day) (Year)

7 AGE

yrs. 1 mos. 21 ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry business, or establishment in which employed (or employer)

Infant9 BIRTHPLACE  
(State or country)Md

## 10 NAME OF FATHER

John Cresswell11 BIRTHPLACE OF FATHER  
(State or country)Md

## 12 MAIDEN NAME OF MOTHER

Bertha J. Miller13 BIRTHPLACE OF MOTHER  
(State or country)Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha J. Cresswell(Address) Perryville Md15 Filed 10/22/15, 1915

L. G. Taylor

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 20, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20th, 1915, to Oct. 20, 1915, that I last saw him alive on Oct. 20, 1915, and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH \* was as follows:

Neocotitis

(Duration) yrs. mos. 6 ds.

Contributory  
Secondary(Signed) Geo. M. Stump & F. M. Magruder, M. D.  
Oct. 22, 1915 (Address) Perryville Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Debary Cemetery, Oct. 22, 1915

## DATE OF BURIAL

## 20 UNDERTAKER

W. C. Jackson, Blythedale ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchiopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	NOV 6 1915
BUREAU, U. S.	

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 1747 103  
County Cecil

Village or City Plummet Deltie (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Thomas Jackson Darlington, Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

## 6 DATE OF BIRTH

April 11, 1864  
(Month) (Day) (Year)

## 7 AGE

51 yrs 6 mos 9 ds.

If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work. Blacksmith  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

Delaware

10 NAME OF  
FATHER

Samuel Darlington

11 BIRTHPLACE  
OF FATHER  
(State or country)

Penna.

12 MAIDEN NAME  
OF MOTHER

Mary Jane Reese

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Delaware

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. J. Darlington

(Address) 6 Fields Rd.

15 Filed Oct 18th, 1915  
By James Fager

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 18 —, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1915, to death, 1915.

that I last saw him alive on Oct 18, 1915,  
and that death occurred on the date stated above, at 8 a.m.  
The CAUSE OF DEATH\* was as follows:

Plants dilatation of heart

Contributory Insanity  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) C. P. Corcoran (Address) Section Rd.  
Oct 19, 1915, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Head of Chestions DATE OF BURIAL Oct 21, 1915

20 UNDERTAKER A. J. Abernathy ADDRESS Section Rd.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial-employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensitis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

Acil  
County

Village or City

North East Md

H

## 2 FULL NAME

Frances L. Deckeran

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

## 6 DATE OF BIRTH

June 7, 1854  
(Month) (Day) (Year)

## 7 AGE

61 yrs. 4 mos. 8 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

At home

## 9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF  
FATHER

John T. Lloyd

11 BIRTH PLACE  
OF FATHER

(State or country)

Maryland

12 MAIDEN NAME  
OF MOTHER

Alice M. Deshant

13 BIRTHPLACE  
OF MOTHER

(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. L. Sonichill

(Address)

North East Md

## 15

Filed Oct 16, 1915 Leggah Bedotie

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Oct. 14, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
July 20, 1915, to Oct. 14, 1915;  
that I last saw her alive on Oct. 14, 1915,  
and that death occurred on the date stated above, at 10 A.M.

## The CAUSE OF DEATH \* was as follows:

Carcinoma of Rectum.

(Duration) yrs. 3 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. 0 mos. 0 ds.

(Signed) Oct. 15, 1915 (Address) North East, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL OR HOMICIDAL18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds.Where disease contracted,  
if not at place of death?Former or  
usual residenceIn the  
State, yrs. mos. ds.

## 19 PLACE OF BURIAL OR REMOVAL

North East St. Marys

## DATE OF BURIAL

Oct 17, 1915

## 20 UNDERTAKER

Kinsinger Pippin

ADDRESS  
Elkton Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal meningitis*; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm(s); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REC'D	VED
NOV 6 1915	BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		STATE OF MARYLAND CERTIFICATE OF DEATH		
County	Cecil	17472	Registration Dist. No. 92	
Village or City	Elkton	(No.)	St.:	Ward)
2 FULL NAME		Willard Shivery Dennis		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	6 DATE OF BIRTH	
Male	White	Single	July	21, 1915
			(Month)	(Day)
			(Year)	
7 AGE	8 OCCUPATION	9 BIRTHPLACE (State or country)	10 NAME OF FATHER	11 BIRTHPLACE OF FATHER (State or country)
2 yrs. 2 mos. 10 ds.	(a) Trade, profession, or particular kind of work.	Maryland	Howard Shivery	Howard Shivery
	(b) General nature of industry, business, or establishment in which employed (or employer)			Moogland
				Helen Dennis
				Maryland
12 MAIDEN NAME OF MOTHER				
13 BIRTHPLACE OF MOTHER (State or country)				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) Lauria Dennis				
(Address) Elkton, Md.				
15	Filed Oct 3, 1915	J. F. Fraser	REGISTRAR	16 DATE OF DEATH
17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1915 to Oct 2, 1915, that I last saw him alive on Oct 2, 1915, and that death occurred on the date stated above, at 1:20 a.m. The CAUSE OF DEATH* was as follows:				
*Cause of death: <i>was called in absence of family physician -</i> <i>had poorly, much emaciated and failed to respond to all treatment - from birth -</i> <i>(Duration) yrs. mos. ds.</i> <i>Contributory: Some gastric hemorrhage that time</i> <i>prior to death (Duration) yrs. mos. ds.</i>				
(Signed) Lauria Dennis, M. D. Oct 4, 1915 (Address) Elkton, Md.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)				
At place of death yrs. mos. ds. In the State yrs. mos. ds.				
Where was disease contracted, if not at place of death?				
Former or usual residence.				
19 PLACE OF BURIAL OR REMOVAL				
North East Oct 4, 1915				
20 UNDERTAKER				
A. J. Abernathy, Elkton, Md.				
ADDRESS				

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

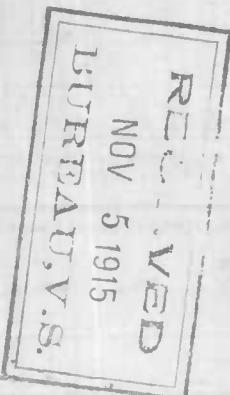
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

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## MARGIN RESERVED FOR BINDING

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## 1 PLACE OF DEATH

County Cecil

17473

175

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Frisbie

(No.)

Cecil County

SL, Ward)

## 2 FULL NAME

Morris Fooks

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
DIVORCED  
(Write the word)

6 Single

7 DATE OF BIRTH

May 18, 1896

(Month)

(Day)

(Year)

8 AGE

19

yrs.

4 mos.

15 ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 9 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry  
business, or establishment in  
which employed (or employer)Chuffer

## 10 BIRTHPLACE

(State or country)

Balto. Md

## PARENTS

## 11 NAME OF FATHER

12 BIRTHPLACE OF FATHER  
(State or country)

## 13 MAIDEN NAME OF MOTHER

14 BIRTHPLACE OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Deveron & Bro

1107 E Balto St

(Address) Balto. Md

15

Filed Oct 4, 1915 Deed B. dolls

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 3rd, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191 , to , 191 ,

that I last saw h alive on , 191 ,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Rueyay  
Struck by train  
accident.

(Duration) yrs. mos. ds.

Contributory  
Secondary(Signed) W. P. Deary Goromer (Duration) yrs. mos. ds.Oct 4, 1915 (Address) Baltimore Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.  
Where was disease contracted,  
If not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Baltimore City DATE OF BURIAL Oct 4, 1915

## 20 UNDERTAKER

J. Grinon & Co ADDRESS 1107 E Balto St

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

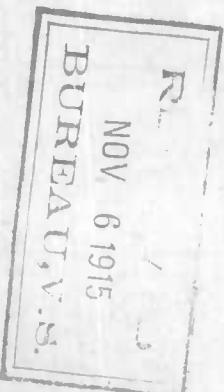
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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: "Measles (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County..... *Harde*..... 17474 (175)

Village or City..... *Frederick County*.....STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *94*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME..... *John Hand*.....

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

(Month) (Day) (Year)

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

1167 E Baltimore St  
(Address) Baltimore Md

15

Filed Oct 4, 1915 Deed Biddle

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 3, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
1911 to 1915, and that I last saw him alive on

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

accidental, care  
into 3000 railroad  
train No 9

(Duration) yrs. mos. ds.

Contributory  
Secondary(Signed) W. P. Dean coroner  
(Address) Oct 4, 1915 Elkton Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted?  
If not at place of death?

Former, or usual residence

19 PLACE OF BURIAL OR REMOVAL

Baltimore City Md unknown, 1915

20 UNDERTAKER

J. L. Johnson &amp; Son Baltimore

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important.

Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
 OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
 County Cecil No. 17475 (79)

Village or City Port Deposit

2 FULL NAME William A Hindman

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED MARRIED (Write the word)

6 DATE OF BIRTH June 24, 1880 (Month) (Day) (Year)

7 AGE 65 yrs. 3 mos. 6 ds. If, LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Retired  
 (b) General nature of Industry business, or establishment in which employed (or employer) Former occupation  
Grocery Salesman

9 BIRTHPLACE  
 (State or country) Cecil Co Md

10 NAME OF FATHER Samuel Hindman

11 BIRTHPLACE OF FATHER  
 (State or country) Unknown

12 MAIDEN NAME OF MOTHER Prudence Woodrow

13 BIRTHPLACE OF MOTHER  
 (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Hannah Hindman  
 (Address) Port Deposit Md

15 Died Oct. 4 1915 At 11 A.M. (Cause of Death) Heart Disease

16 DATE OF DEATH Oct - 1 - 1915 (Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from February, 1915, to August 27, 1915  
 that I last saw him alive on August 27, 1915  
 and that death occurred on the date stated above, at 105 p.m.

MEDICAL CERTIFICATE OF DEATH

The CAUSE OF DEATH was as follows:  
Acute & Dilatation of Heart

Contributory  
 Secondary Chronic Endocarditis (Duration) yrs. mos. / ds.

(Signature) B J Benson (Address) Port Deposit Md. (Duration) yrs. mos. / ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)  
 At place of death yrs. mes. ds.  
 Where was disease contracted,  
 If not at place of death?  
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL West Nottingham Cemetery DATE OF BURIAL Oct 4 1915

20 UNDERTAKER W C Jackson Blythdale ADDRESS

REGISTRAR

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia* ("Pneumonia", "unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Brachypterygium* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Colitis," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæma," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rebuker wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 5 1915

BUREAU U. S.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Cecil

17493

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Port Deposit (No. 175)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Horsey Jack

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

June 26 th 1874  
(Month) (Day) (Year)

7 AGE

41 yrs. 3 mos. 9 ds.If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Jack(Address) Port Deposit Md

15

Filed Oct. 12, 1915

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct. 9, 1915, to Oct. 9, 1915,  
that I last saw him dead on Oct. 9, 1915,and that death occurred on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH \* was as follows:

Stricture of base of skull  
Protrusion of both lobes  
Wounding in a sword fight where hand  
Fell on hand 11/12 (Duration) 15 min. yrs. mos. daysContributory  
Secondary  
Pressure on brain from  
hemorrhage (Duration) 15 min. yrs. mos. days  
(Signed) W. P. Dean (Address) Edgewater Md.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place \_\_\_\_\_  
at death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.Where was disease contracted,  
if not at place of death?Former or  
usual residenceIn the  
State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

19 PLACE OF BURIAL OR REMOVAL

Hopewell Cemetery DATE OF BURIAL  
Oct. 12, 1915

20 UNDERTAKER

Slater B. Lark ADDRESS  
Colora

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebral spinal meningitis*); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," ("Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marmasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæma," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverb. wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 5 1915
BUREAU, U.S.

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1 PLACE OF DEATH  
County Cecil

17477

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 93Village or City Fair-Hill (No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ann Jamison

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Female</u>	<u>White</u>	<u>Married</u>
6 DATE OF BIRTH		July 24, 1840
		(Month) (Day) (Year)
7 AGE		75 yrs. 2 mos. 20 ds.
		If LESS than t day, hrs. OR min.?

8 OCCUPATION  
 (a) Trade, profession, or  
particular kind of work.  
 (b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Housewife

9 BIRTHPLACE  
(State or country) New-Castle Co. Del.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER  
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER  
(State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Jamison  
(Address) Elkton Md.

15

Filed 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1915, to Oct 13, 1915,  
that I last saw him alive on Oct 13, 1915,  
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH\* was as follows:

Lehronic Bronchitis

Contributory  
Secondary Dysentery (Duration) 2 yrs. 2 mos. 20 ds.

(Signed) L. P. Lehronic (Address) Foyston Md. (Duration) 1 yrs. 1 mos. 10 ds. M. D. Oct 15, 1915

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Elkton Md. DATE OF BURIAL Oct 16, 1915

20 UNDERTAKER B. E. Mason

ADDRESS NottinghamR. L. Pa.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

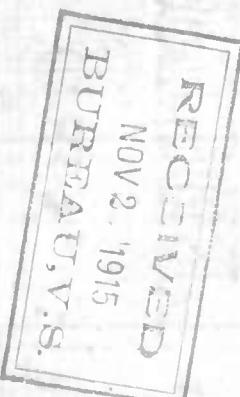
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*Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (nearly symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Convulsive"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal pueritis," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil 17478  
Village or City Berryville (No. 104)  
2 FULL NAME Mary E. McMullen

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Feb. 2, 1895  
(Month) (Day) (Year)

7 AGE 8 yrs. 3 mos. 3 ds. If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION Infant  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE Md.  
(State or country)

10 NAME OF FATHER Oscar McMullen

11 BIRTHPLACE OF FATHER Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Richardson

13 BIRTHPLACE OF MOTHER Md.  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Oscar McMullen  
(Address) Berryville Ind

15 Filed Oct. 7, 1915 by F. M. Cannon

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 96

St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

16 DATE OF DEATH Oct. 5, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from September 28, 1915, to October 30, 1915, that I last saw him alive on October 30, 1915, and that death occurred on the date stated above, at 30 m. The CAUSE OF DEATH \* was as follows: Geo. Colitis

(Duration) 14 yrs. mos. 14 ds.

Contributory  
Secondary

(Signed) Geo. M. Humpf, Jr., M. D. (Address) Berryville, Md. (Duration) 14 yrs. mos. 14 ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place  
at death yr. mos. ds.  
Where was disease contracted,  
If not at place of death?  
Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Ashley Cemetery DATE OF BURIAL Oct. 7, 1915

20 UNDERTAKER W. C. Jackson ADDRESS Betheldale Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

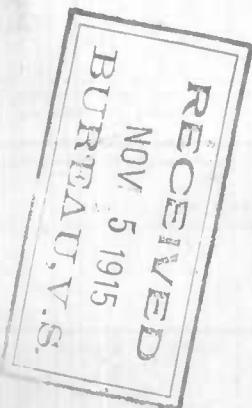
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil 17479 (S)

Village or City Near Port Deposit (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mur

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
---------------------	------------------------------	---

6 DATE OF BIRTH Oct 5(Month) (Day) (Year) (Month) (Day) (Year)

## 7 AGE

YRS. 20 MOS. 0 DS. 0If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work..

(b) General nature of industry, business, or establishment in which employed (or employer) Near Post deposit

## 9 BIRTHPLACE

(State or country) Near Post deposit

## 10 NAME OF FATHER

Stanley R. May

## 11 BIRTHPLACE OF FATHER

(State or country) Beth Ball M.D.

## 12 MAIDEN NAME OF MOTHER

Ursula Campbell

## 13 BIRTHPLACE OF MOTHER

(State or country) Principio M.D.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Slocum M.D.(Address) Rising Sun M.D.

## 15

Filed 1915

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5(Month) (Day) (Year) (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1915, to Oct 5, 1915,that I last saw him alive on Oct 5, 1915,and that death occurred on the date stated above, at Oct 5, 1915,

The CAUSE OF DEATH\* was as follows:

Death caused from birthstill birth

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) John May Jr. M.D. (Address) Rising Sun M.D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

W. S. Slocum DATE OF BURIAL Oct 5, 1915

## 20 UNDERTAKER

John A. Taylor ADDRESS Rising Sun M.D.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dey laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB - 1916

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

Cecil

17480

County

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Elkton Union Hospital

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sarah Matilda Meisel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED

Sug E

7 OR DIVORCED

(Write the word)

6 DATE OF BIRTH

Dec

13

, 1899

(Month)

(Day)

(Year)

7 AGE

15

9

mos. 27

ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

at home

(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF  
FATHER

Wm. H. Meisel

11 BIRTHPLACE  
OF FATHER

(State or country)

Maryland

12 MAIDEN NAME  
OF MOTHER

Margaret Butcher

13 BIRTHPLACE  
OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Margaret Meisel

(Address)

Elkton, Md

15

Filed Oct 13, 1915

of Dr. Frank Fager

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct

10

, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1915, to Oct 10, 1915, that I last saw her alive on Oct 10, 1915, and that death occurred on the date stated above, at 7 P. m. The CAUSE OF DEATH \* was as follows:

Dilatation of Heart

Contributory  
Secondary

(Duration) yrs. months. days.

Chemic Endocarditis

(Signed)

H. Arthur Mitchell, M. D.

10/12, 1915

(Address) Elkton, Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 15 yrs. mos. ds. In the 15 yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

Elkton, Md

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL

Oct 13, 1915

20 UNDERTAKER

Vinson &amp; Pippin

ADDRESS

Elkton, Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal*, *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 5 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County: Cecil

17481

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 90Village or City: West Cecil(No. 168)

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

George R. Moffett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

4 10, 1906

(Month) (Day) (Year)

7 AGE

9 yrs. 6 mos. — ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)At Home

9 BIRTHPLACE

(State or country)

Kent Co. Del.10 NAME OF  
FATHERGeorge R. Moffett11 BIRTHPLACE  
OF FATHER

(State or country)

Delaware Co. Del.12 MAIDEN NAME  
OF MOTHERMary E. McDowell13 BIRTHPLACE  
OF MOTHER

(State or country)

Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo R Moffett

(Address)

Cecilton Md

15

Filed

Oct 12, 1915

J.W. Blaet

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 10, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Oct 3, 1915, to Oct 10, 1915,that I last saw him alive on Oct 10, 1915,  
and that death occurred on the date stated above, at 1630 p.m.

The CAUSE OF DEATH \* was as follows:

Pentoxil and  
Intestinal Obstruction  
(Duration) yrs. mos. 10 ds.Contributory  
SecondaryAppendicitisSIGNED St. Anthony Hospital  
Oct 11, 1915 (Address) Cecilton Md  
(Duration) yrs. mos. 6 ds.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place yrs. mos. 10 ds. In the State, yrs. mos. — ds.

Where was disease contracted, State, yrs. mos. — ds.

If not at place of death?

Former or  
usual residence near Cecilton Md19 PLACE OF BURIAL OR REMOVAL St. Xavier Cemetery DATE OF BURIAL  
Oct 13, 1915

20 UNDERTAKER

John J. Coffey ADDRESS Cecilton Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**  
**N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.**

1 PLACE OF DEATH County <i>Cecil</i>		17489	(105)
Village or City <i>Perryville</i>		No. <i>10</i>	(104)
2 FULL NAME <i>Carl H. Montgomery</i>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>Male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>single</i>	
6 DATE OF BIRTH <i>December 31, 1911</i>		(Month) <i>December</i>	(Day) <i>31</i>
7 AGE <i>3 yrs.</i>	<i>9 mos.</i>	<i>26 ds.</i>	If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>None</i>		(b) General nature of industry business, or establishment in which employed (or employer) <i>None</i>	
9 BIRTHPLACE (State or country) <i>Maryland</i>		10 NAME OF FATHER <i>Wm. H. Montgomery</i>	
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>		12 MAIDEN NAME OF MOTHER <i>Hattie Scantling</i>	
13 BIRTHPLACE OF MOTHER (State or country) <i>Virginia</i>		14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Wm. H. Montgomery</i>	
(Address) <i>Perryville</i>		15 Filed <i>Oct. 27, 1915</i>	

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. *96*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *October 26<sup>th</sup>, 1915*  
(Month) *October* (Day) *26* (Year) *1915*

17 I HEREBY CERTIFY, That I attended deceased from *October 9, 1915*, to *October 26<sup>th</sup>, 1915*, that I last saw him alive on *October 26<sup>th</sup>, 1915*, and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH \* was as follows:

*Sted. Cottis*(Duration) *17* yrs. *17* mos. *17* ds.Contributory *Convulsions*  
Secondary(Duration) *17* yrs. *17* mos. *17* ds.

(Signed) *Geo. W. Steepe Maguire, M. D.* (Address) *Perryville, Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
at death *1815* yrs. *1815* mos. *1815* ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL *Principio Cemetery* DATE OF BURIAL *Oct. 29, 1915*20 UNDERTAKER *Geo. Patterson*ADDRESS *Perryville*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil 17488

Village or City Fredericktown No. 1

## 2 FULL NAME

George G. Morgan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

## 6 DATE OF BIRTH

6 / 1, 1842 (Month) (Day) (Year)

## 7 AGE

73 yrs. 4 mos. 29 ds.

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE  
(State or country)

Cecil County Md.

## 10 NAME OF FATHER

John W. Morgan

11 BIRTHPLACE OF FATHER  
(State or country)

Cecil Co. Md.

## 12 MATURE NAME OF MOTHER

Mary W. Hale

13 BIRTHPLACE OF MOTHER  
(State or country)

Cecil Co. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo G. Morgan Jr.

(Address) Cecilton Md.

## 15

Filed Nov 1st, 1915 J. H. Black

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

79

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

10 Oct, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from home, 1915, to October 29, 1915, that I last saw him alive on October 29, 1915, and that death occurred on the date stated above, at 1:00 m.

## The CAUSE OF DEATH \* was as follows:

Chronic valvular disease

of heart

(Duration) 6 yrs. mos. ds.

Contributory  
Secondary

odema frig. (Duration)  yrs. mos. ds.

(Signed) John W. Lamer (Address) Galena Md. M. D.

, 1915. (Address) Galena Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Cecilton Md. DATE OF BURIAL Nov 1st, 1915

## 20 UNDERTAKER

John S. Coffey ADDRESS Cecilton Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm(s); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important.

Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," ("Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal sepihaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County *Perryville* 17484

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 7

Village or City *Perryville*(No. *Many lands*)St. *Ward*)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Margaret M. Morris*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*single*6 DATE OF BIRTH *December 7, 1914*

(Month)

(Day)

(Year)

7 AGE *9 yrs. 27 mos. 27 ds.*if LESS than  
1 day, .... hrs.  
OR min. ?8 OCCUPATION *Morrie*(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer) *Morrie*9 BIRTHPLACE *Maryland*

(State or country)

10 NAME OF  
FATHER *Normand Morris*11 BIRTHPLACE  
OF FATHER *Maryland*  
(State or country)12 MAIDEN NAME  
OF MOTHER *Carrie Brown*13 BIRTHPLACE  
OF MOTHER *Maryland*  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Carrie Brown*

15

(Address) *Perryville Md.*Filled *10/6/15, 1915*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 5, 1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 28, 1915* to *Oct 4<sup>th</sup>, 1915*, that I last saw h. m. alive on *Oct 4<sup>th</sup>, 1915*and that death occurred on the date stated above, at *8:45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Influenza**Ten days* (Duration) yrs. mos. ds.Contributory *Improper food* Secondary(Signed) *Dr. W. Flynn*, M. D. (Address) *Perryville Md.*

61-5, 1915

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Nottingham Cemetery* DATE OF BURIAL *Oct. 7, 1915*20 UNDERTAKER *L. A. Patterson*ADDRESS *Perryville Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Masmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
NOV 6 1915

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH *Cecil* 17485 (48)

County *Port Deposit* Village or City *Georgina Davies*

2 FULL NAME *Georgina Davies*

3 SEX *Female* 4 COLOR OR RACE *Brown*

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Widow*

6 DATE OF BIRTH *November 15, 1864* (Month) (Day) (Year)

7 AGE *50 yrs. 11 mos. 2 ds.* If LESS than 1 day, hrs. OR min.?

8 OCCUPATION  (a) Trade, profession, or particular kind of work *Housewife*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*

9 BIRTHPLACE (State or country) *Alma Brandon Co. Md.*

10 NAME OF FATHER *John W. Thomas*

11 BIRTHPLACE OF FATHER (State or country) *Albuquerque*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (State or country) *Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *James J. Young*  
 (Address) *Port Deposit*

15 Filed *Oct. 19, 1915 - M.R. Damron*

16 PLACE OF BURIAL OR REMOVAL *Cokesbury Cemetery* DATE OF BURIAL *Oct 19, 1915*

17 UNDERTAKER *W. C. Jackson Blythdale* ADDRESS *Ind*

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence \_\_\_\_\_

19 MEDICAL CERTIFICATE OF DEATH  
 16 DATE OF DEATH *Oct - 17 - 1915* (Month) (Day) (Year)  
 17 I HEREBY CERTIFY That *Georgina Davies* deceased from *Sept. 15, 1915* to *Oct 17, 1915*, that I last saw her alive on *Oct 17, 1915*, and that death occurred on the date stated above, at *3:15 p.m.*  
 The CAUSE OF DEATH \* was as follows:  
*Carcinoma of uterus* (Duration) *2 yrs. mos. ds.*  
 Contributory Secondary \_\_\_\_\_  
 (Signed) *W. C. Jackson* (Address) *Port Deposit* M.D.

\* State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

20 REGISTRAR

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

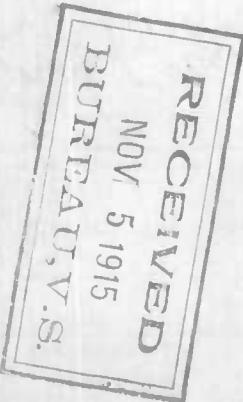
**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, *e. g.*, *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cod*, *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated—unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County.....		17486
Cecil		
Village or City.....		Cherry Hill (No.)
2 FULL NAME..... Margaret Eleanor Peacock		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
6 DATE OF BIRTH February 21st, 1844		
(Month)		(Day)
(Year)		
7 AGE 71 yrs. 7 mos. 10 ds.	If LESS than 1 day, ____ hrs. OR ____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work at Home		
(b) General nature of industry, business, or establishment in which employed (or employer) None		
9 BIRTHPLACE (State or country) Cecil County, Maryland		
10 NAME OF FATHER Joseph Gibson		
11 BIRTHPLACE OF FATHER (State or country) Penna.		
12 MAIDEN NAME OF MOTHER Jane Elizabeth Knight		
13 BIRTHPLACE OF MOTHER (State or country) Maryland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant..... Charles S. Peacock (Address) Elkton, Md.		
15 Filed..... 191		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 93

St. \_\_\_\_\_ Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
October 1st, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Sept 27, 1915, to Oct 1, 1915,

that I last saw her alive on Oct 1, 1915

and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH\* was as follows:

Aphoplexy

(Duration) yrs. 5 mos. — ds.

Contributory  
Secondary Extraneous

(Duration) yrs. 21 mos. — ds.

(Signed) Oct 4, 1915 (Address) H. Arthur Butcher, M. D. Elkton, Md.

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
Cherry Hill Cemetery Oct 5, 1915  
DATE OF BURIAL20 UNDERTAKER  
C. S. Grant ADDRESS  
Cherry Hill Md.

REGISTRAR

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

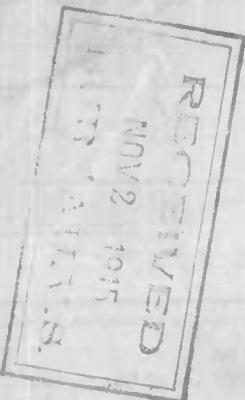
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm-laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Coturnism," "Convulsions," "Debility" ("Con genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH	
County	17487
Village or City	Cherry Hill (No.)
2 FULL NAME	
PERSONAL AND STATISTICAL PARTICULARS	
3 SEX	4 COLOR OR RACE
Female	Black
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED	6 MARRIED
(Write the word)	
7 AGE	
8 DATE OF BIRTH	unknown (Month) 1 (Day) 1 (Year)
9 OCCUPATION	(a) Trade, profession, or particular kind of work No (b) General nature of industry, business, or establishment in which employed (or employer)
10 NAME OF FATHER	
11 BIRTHPLACE OF FATHER (State or country)	
12 MAIDEN NAME OF MOTHER	
13 BIRTHPLACE OF MOTHER (State or country)	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	
(Informant)	James Hartnett
(Address)	Le Bldgs. Md.
15	1915
Filed	Oct 9, 1915
Signature of Informant	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *gr*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH	Oct. 8, 1915 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1915, to Oct 8, 1915,	
that I last saw her alive on Oct 7, 1915,	
and that death occurred on the date stated above, at	
The CAUSE OF DEATH* was as follows:	
<i>Pneumonia</i>	
(Duration) yrs. mos. ds.	
Contributory Secondary	
(Duration) yrs. mos. ds.	
(Signed) <i>John Crowley</i> , M. D.	
(Address) Oct 9, 1915	
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
At place of death yrs. mos. ds. In the State yrs. mos. ds.	
Where was disease contracted, if not at place of death?	
Former or usual residence	
19 PLACE OF BURIAL OR REMOVAL	
20 UNDERTAKER	DATE OF BURIAL
ADDRESS	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

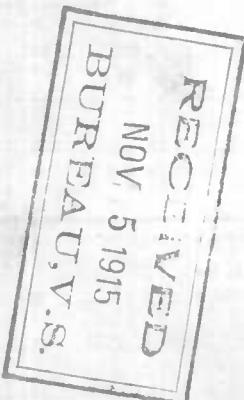
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Cord-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <i>Baltimore Co.</i>		17188 134 77
Village or City <i>Mr Charles Ward</i>		(No.)
2 FULL NAME <i>Florence Gertrude Scott</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>F</i>	4 COLOR OR RACE <i>W</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>MARRIED</i>
6 DATE OF BIRTH <i>June 11, 1890</i> (Month) (Day) (Year)		
7 AGE <i>25 yrs. 3 mos. 28 ds.</i>	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>House wife</i>		
9 BIRTHPLACE (State or country) <i>Pa</i>		
10 NAME OF FATHER <i>James G. MacLennan</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Pa</i>		
12 MAIDEN NAME OF MOTHER <i>Marguerite</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Pa</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Eliza Scott MacLennan</i> (Address) <i>Charles Ward</i>		
15 Filed _____, 191		

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *93*[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <i>October 16th, 1915</i> (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended deceased from <i>Sept 4th, 1915, to Oct 16th, 1915</i> that I last saw her alive on <i>Oct 16th, 1915</i> and that death occurred on the date stated above, at <i>10 a.m.</i> The CAUSE OF DEATH* was as follows: <i>Infra-red sequestration of the walls of the heart</i>	
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds Where was disease contracted, if not at place of death? Former or usual residence _____		
19 PLACE OF BURIAL OR REMOVAL <i>Rosebank</i>	DATE OF BURIAL <i>Oct 19, 1915</i>	20 UNDERTAKER <i>Edmund</i>
ADDRESS <i>Newark, Del.</i>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

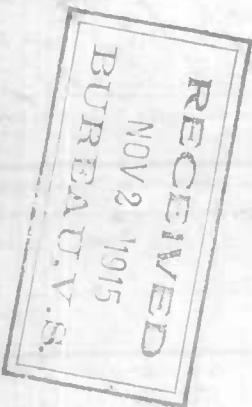
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dull laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Dehility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH *Acil* 17489  
 County *Elkton* (No. 104)

2 FULL NAME *Leroy James Sykes Jr*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
 (Write the word)

6 DATE OF BIRTH *Nov 10, 1914*  
 (Month) (Day) (Year)

7 AGE *— yrs. 11 mos. 17 ds.* If LESS than  
 1 day, hrs.  
 OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work *—*  
 (b) General nature of industry business, or establishment in which employed (or employer) *—*

9 BIRTHPLACE (State or country) *Maryland*

PARENTS

10 NAME OF FATHER *Leroy J Sykes*  
 11 BIRTHPLACE OF FATHER (State or country) *Maryland*  
 12 MAIDEN NAME OF MOTHER *Irene Clay*  
 13 BIRTHPLACE OF MOTHER (State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *Mr. Irene Sykes*  
 (Address) *Elkton Md*

15 Filed *Oct 30, 1915* *J. James Drayton*  
 REGISTRAR

STATE OF MARYLAND  
 CERTIFICATE OF DEATH  
 Registration Dist. No. *92*  
 St.; Ward)  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 27, 1915*  
 (Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from *Oct 23, 1915* to *Oct 27, 1915*, that I last saw him alive on *Oct 27, 1915*, and that death occurred on the date stated above, at 4 P.M. The CAUSE OF DEATH \* was as follows:

*Gas in Enter Colitis (acute)*

(Duration) *6 ds.*

Contributory  
 Secondary *H. Arthur Mutchey*  
 (Signature) *Oct 29, 1915* (Address) *Elkton Md*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place  
 of death *— yrs. — mos. — ds.* In the  
 Where was disease contracted, State, *— yrs. — mos. — ds.*  
 If not at place of death?  
 Former or  
 usual residence

19 PLACE OF BURIAL OR REMOVAL *Elkton Cemetery* DATE OF BURIAL *Oct 30, 1915*

20 UNDERTAKER *Vinson & Pippin* ADDRESS *Elkton Md*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery merchant*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer," is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tdamitus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

17494 (110) (100)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City Cherry Hill (No. Alms House)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Harry Harrington

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>blk</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
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## 6 DATE OF BIRTH

1 (Month) 1 (Day) 1915 (Year)

7 AGE <u>2</u> yrs.	mos. <u>0</u>	ds. <u>0</u>	if LESS than 1 day, ____ hrs. OR ____ min. ?
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## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Painter  
(b) General nature of industry, business, or establishment in which employed (or employer) Painting

9 BIRTHPLACE  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Hartnett

(Address) 6 Fields, Md.

15 Filed Oct 16, 1915 by Frank Frazer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Oct 15, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to Oct 15, 1915;

that I last saw him alive on Oct 10, 1915;

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

Bright's Disease

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) John Hawley, M. D. (Address) Baltimore

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cherry Hill Pottery Oct 16, 1915

## 20 UNDERTAKER ADDRESS

Cherry Hill Pottery Elkton

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Petebility" ("Contagital"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
NOV 5 1915  
BUREAU, U. S. S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH *Elk* 17490 113

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *gr*

County *Elk* Village or City *Elk* (No. *113*, Street; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Ross Watson*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6 DATE OF BIRTH *Nov. 1, 1846* (Month) (Day) (Year)

7 AGE *69* yrs. *00* mos. *00* ds. If LESS than 1 day, *00* hrs. OR *00* min.?

8 OCCUPATION *Fisherman*

10 BIRTHPLACE (State or country) *Baltimore Md.*

11 BIRTHPLACE OF FATHER (State or country) *Robert Watson*

12 MAIDEN NAME OF MOTHER *Elizabeth Reed*

13 BIRTHPLACE OF MOTHER (State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Mrs. W. S. Campbell* (Address) *Leah Hospital Elk Md.*

15 Filed *Oct 24, 1915* by *James Fager* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *October 23, 1915* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 14, 1915*, to *Oct 23, 1915*, that I last saw him alive on *Oct 23, 1915*, and that death occurred on the date stated above, at *Elk Md.* The CAUSE OF DEATH \* was as follows: *Curhous of liver*

Contributory *Secondary* (Burial) *1* yrs. *00* mos. *00* ds.

(Signed) *H. Arthur Fletcher* (Burial) *1* yrs. *00* mos. *00* ds. (Address) *Elk Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place *Chesapeake City Md.* Is the State, *69* yrs. *00* mos. *00* ds. of death *00* yrs. *00* mos. *00* ds. Where disease contracted, *Chesapeake City Md.* If not at place of death? Former or usual residence *Chesapeake City Md.*

19 PLACE OF BURIAL OR REMOVAL *Bethel Cemetery* DATE OF BURIAL *Oct 25, 1915*

20 UNDERTAKER *J. C. Leffler* ADDRESS *Chesapeake City Md.*

# REVISED UNITED STATES STANDARD

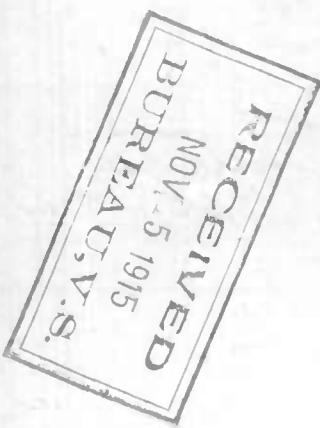
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.) If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
Cecil County

17491

1578

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City  
Charleston (No.)

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Gladys Webber

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	single

6 DATE OF BIRTH  
Oct 17, 1915  
(Month) (Day) (Year)

7 AGE  
0 yrs. 0 mos. 8 ds. If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work.  
None  
(b) General nature of Industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Cecil County

10 NAME OF FATHER Mr. L. Webber

11 BIRTHPLACE OF FATHER (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Elsie Foyan

13 BIRTHPLACE OF MOTHER (State or country) Cecil Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. G. Webber  
(Address) Charleston

15 Filed Oct. 25, 1915 - M. G. Damron

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 25, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1915, to Oct 25, 1915,  
that I last saw her alive on Oct 24, 1915,

and that death occurred on the date stated above, at 1145 A.M.

The CAUSE OF DEATH \* was as follows:

Congenital Atrial Septal Defect

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) W. G. Webber (Address) Main St. and N. O.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. do.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Charleston Cemetery Oct 26, 1915

20 UNDERTAKER ADDRESS  
Lee A. Patterson Perryville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Cecil

17492

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City Port Deposit (No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edna May Woodrow

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Female</u>	<u>white</u>	<u>Single</u>

DATE OF BIRTH

Sept - 29A, 1915  
(Month) (Day) (Year)

7 AGE

yrs. — mos. — ds.

If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None. Infant9 BIRTHPLACE  
(State or country)Port Deposit Md10 NAME OF  
FATHERS Frank Woodrow11 BIRTHPLACE  
OF FATHER  
(State or country)Cecil Co Md12 MAIDEN NAME  
OF MOTHEREdna S Kennedy13 BIRTHPLACE  
OF MOTHER  
(State or country)Lancaster Co Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S Frank Woodrow

(Address)

Port Deposit Md

15

Filed Oct. 4 - 1915by S. R. Cameron

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 2, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 29, 1915, to Oct 3, 1915,that I last saw her alive on Oct 3, 1915,and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis  
Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary Pneumonia Acme Bungs

(Duration) yrs. mos. ds.

(Signed) M. F. Jack (Address) Port Deposit Md M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,  
If not at place of death?Former or  
usual residence.19 PLACE OF BURIAL OR REMOVAL West Nottingham Grnd. DATE OF BURIAL Oct. 5th, 191520 UNDERTAKER Slater B. Job

ADDRESS

Cecil Co Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day Laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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OCT 5 1915
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